C.	Technical Approach

26.	**Program Integrity** *(Section 36.0 Program Integrity)*

APPROACH TO PROGRAM INTEGRITY

Humana has participated in publicly-financed healthcare programs since the mid-1980s, allowing us to develop deep expertise in the investigation and mitigation of fraud, waste, and abuse (FWA). We view FWA as a company-wide responsibility, and we have more than 4,100 associates engaged in FWA activities, including prevention, detection, and investigation. We have made substantial investments in our FWA efforts, developing new tools such as our Fraud Investigation Tracker (FIT), Total Humana Overpayment Resolution (THOR) system, and various analytic dashboards, in order to continuously improve our FWA processes. We also leverage our expertise in areas such as cyber security and risk identification to further expand our FWA prevention and detection activities.

Recognized as a national leader, we are actively involved with or hold a leadership role in multiple national anti-fraud organizations, including the National Health Care Anti-Fraud Association (NHCAA) and the Midwest Anti-Fraud Insurance Association (MAIA). We are also one of the founding members of the Healthcare Fraud Prevention Partnership (HFPP), an innovative public-private partnership with the Department of Health and Human Services (HHS) following passage of the Affordable Care Act (ACA). We participate actively in Kentucky-based efforts such as the monthly Managed Care Organization (MCO) Investigation Calls and Kentucky Quarterly Meetings with US attorneys, the Office of Medicaid Fraud and Abuse (OMFA), the Office of Inspector General (OIG), Program Integrity, and MCOs.

We have provided services in Kentucky through our various programs and services, such as our Medicare, Commercial, and TRICARE lines of business since 1961. **We currently have more than 500 associates across our FWA functions based in the Commonwealth of Kentucky; 14 of these associates are dedicated specifically to our Special Investigations Unit (SIU)**. We are dedicated to being a true partner to the Department for Medicaid Services (DMS), the Kentucky Medicaid Fraud Control Unit (MFCU), and the OIG. Humana has built our FWA efforts on a local-national structure with local associates, whom we support with additional corporate resources, dedicated solely to local issues that arise in Kentucky. Today, our Program Integrity Coordinator, Christina Mayes, and our two full-time investigators Kevin Wade and Ashley Matheny are located in and dedicated to the Kentucky Medicaid program.

ORGANIZATIONAL STRUCTURE

Board of Directors: Humana's culture of compliance begins with our Board of Directors and executive leadership. Humana's Chief Executive Officer (CEO), Bruce Broussard, and the Board of Directors actively engage in oversight of our FWA functions.

Corporate Chief Compliance Officer and Corporate Compliance Committee: Humana's Corporate Chief Compliance Officer (CCO), Sean O'Reilly, who also serves as our Medicare-Medicaid Compliance Officer, reports directly to the Board and the CEO regarding compliance activities, and administratively report to the Chief Risk Officer, Sam Deshpande. Mr. O'Reilly is responsible for the day-to-day ownership of the Corporate Compliance Program and chairs the Corporate Compliance Committee, which monitors issues, metrics, and training as well as adherence to our compliance policies and procedures. The committee is accountable to and provides regular reports to Mr. Broussard and provides compliance plan status updates to the Audit Committee of the Board of Directors.

In addition, our Medicaid CCO, Kimberly Myers, brings more than seven years of Kentucky Medicaid compliance experience as well as program integrity, privacy, and delegation oversight. She is located in Kentucky and is fully dedicated to our Kentucky Medicaid Managed Care (MMC) program. She serves as the primary contact for DMS on Contract compliance issues.

Enterprise Risk Management (ERM) Committee: This committee provides executive management oversight of Humana's ERM program, which is a formal, structured program to manage risk across Humana. It includes structural elements to identify, mitigate, and report risks internally and externally, if necessary. This comprehensive process applies to all lines of business and departments and includes a focus on fraud as an element of operational risk management.

Regulatory Compliance Committee: Our Regulatory Compliance Committee, which we call our Medicare-Medicaid Compliance Committee, is responsible for the oversight of Humana's Medicare and Medicaid programs. This Committee is accountable to and provides regular compliance reports via the CCO to Humana's Corporate Compliance Committee, Humana's CEO Mr. Broussard, and Audit Committee of the Board of Directors. This Corporate Compliance Committee is comprised of our executive leadership, including our Corporate CCO, Mr. O'Reilly, and Chief Accounting Officer, Cynthia Zipperle, as well as other senior leaders.

Medicaid Compliance Committee: In addition, we have a Medicaid Compliance Committee that focuses solely on review and oversight of Medicaid compliance issues. This committee is comprised of representatives from a plurality of teams, including Grievances and Appeals, Operational Risk Management, Regulatory Compliance, and Risk Management. The committee meets monthly to monitor internal Medicaid compliance risks and report these risks to the Regulatory Compliance Committee. The participants use the Medicaid Integrated Compliance Scorecard to drive discussion, which provides the opportunity to monitor and report on Medicaid compliance risks. We share scorecards, dashboards, and the results of the Regulatory Compliance Committee meeting with senior leaders across Humana, including our Corporate CCO, Mr. O'Reilly, President of Medicare/Medicaid Operations, Alan Wheatley (i.e., President of Retail), Vice President of Medicaid, John Barger, and other senior leaders.

Enterprise Investigations Consortium (EIC): Our EIC provides an integrated framework to develop and document investigations, including those related to FWA, criminal activity, ethics, and/or regulatory violations, across all of our operations. The EIC exists to optimize effectiveness within and across the various investigative groups and to ensure our investigative standards consistently exceed legal and compliance requirements. The EIC includes at least one member of each of the following departments: Agent Investigation Unit, Associate Relations, CyberSecurity Operations Center, Enterprise Information Protection, Ethics and Compliance, Forensic Security Investigations, Humana Global Security, Humana Government Business, Inc., Law Department, MarketPoint Sales Integrity, Pharmacy Audit, Privacy, Regulatory Compliance, Enterprise Risk Management (ERM), Claims Cost Management (CCM), Risk Adjustment Integrity Unit (RAIU), and SIU.

Compliance Plan: Our Compliance Plan, which incorporates our Anti-Fraud Plan, describes our mechanisms to prevent and correct fraud risk events. Our Compliance Plan describes our expectations and mandates annual training for all providers, associates, and material Subcontractors. Our Compliance Plan incorporates the HHS OIG guidance and its seven required elements and is structured to adhere to all relevant federal and State requirements, contractual and regulatory requirements, and our Code of Conduct.

Program Integrity Plan: Our Program Integrity (Anti-Fraud) Plan articulates Humana's strategic efforts to detect FWA internally and amongst our Enrollees, providers, and Subcontractors. It describes the data we review, the types of reviews we conduct (e.g., monitoring of provider and Subcontractor services patterns, use of code and payment edits, random claims payment reviews, and routine validation of data and services provided), the controls we have in place, and the steps we take throughout our investigation process. Our Program Integrity (Anti-Fraud) Plan also describes in detail our training plan for our associates, providers, and Subcontractors, as well as Enrollee FWA education. Our SIU Director, David Popik, is responsible for our Program Integrity (Anti-Fraud) Plan, and our Kentucky Medicaid Program Integrity Coordinator, Christina Mayes, in collaboration with

our Kentucky Medicaid CCO, Kimberly Myers, is responsible for ensuring we modify the Program Integrity (Anti-Fraud) Plan to address the requirements of the Kentucky MMC program.

In addition to our Compliance Plan and Program Integrity (Anti-Fraud) Plan, we have numerous policies, procedures, and systems evidencing our compliance with Section 36.1G of the Draft Medicaid Contract.

OPERATIONAL STRUCTURE

In September 2017, Humana took a progressive step within the healthcare industry by creating a Chief Risk Office, uniting our risk and compliance organizations to ensure easier collaboration while maintaining strong partnerships across our operations. The Chief Risk Office, led by Sam Deshpande, sets direction and establishes policy in the areas of ERM and compliance while building a strategy and culture that manages risk appropriately and establishing a consistent definition of risk across the enterprise. An ERM team led by Humana's former SIU Director is building a framework to better identify FWA across the company, including areas traditionally considered FWA, as well as other types of FWA such as associate waste, and then reviewing how to mitigate it. This requires business process owners to think about fraud risk as part of their overall primary responsibility. ERM produces scorecards and other metrics to demonstrate risk reduction and success.

Claims Cost Management (CCM): Operating for more than 30 years, CCM is Humana's overarching department responsible for carrying out our FWA efforts. **CCM has more than 500 associates located in Kentucky**. Our CCM has a Shared Services team with cross-functional responsibilities, such as the CCM Compliance team, as well as sub-units that have their own area of expertise, such as clinical audits, special investigations, complex data analysis, risk adjusted payment integrity, and subrogation. Our CCM has systems to monitor for known FWA types or patterns and aggressively investigate new risk areas. Associates use data mining, query development, and medical record reviews to detect, identify, investigate, and mitigate FWA. CCM manages various services to monitor the accuracy of claim and encounter payments and limit Humana's exposure to fraudulent, wasteful, and abusive healthcare clinical and billing practices.

Special Investigations Unit (SIU): Formed in 1985, our SIU is a sub-unit of CCM and responsible for all investigations related to fraud and abuse. The goals of Humana's SIU department include, but are not limited to, maintaining an anti-fraud program to protect Humana and government funds, conducting thorough and effective investigations into alleged FWA, reporting suspected fraudulent acts to the appropriate federal or State agencies, and cooperating with the agencies' subsequent actions.

Humana's SIU has more than 115 associates dedicated to this function, including 14 Kentucky-based associates. While each referral and case is inherently unique, our SIU investigators employ a systematic set of investigational techniques to thoroughly complete each case review. The SIU tracks incoming complaints, tips, and authorizations in our Fraud Investigation Tracking (FIT) system, which is SIU's proprietary workflow and documentation system. As the case progresses, our investigators document the steps they take in FIT and attach electronic copies of all documents pertaining to the case and its resolution. Our SIU is responsible for communicating with law enforcement officials and will report any suspected fraud activity in accordance with Section 36 of the Draft Medicaid Contract.

Provider Payment Integrity (PPI): As a sub-unit of CCM, PPI conducts reviews and audits related to waste and abuse, along with handling all written inquiries related to overpayments. PPI uses complex data analytics, including outlier analysis, trending, and link analysis to identify potential waste and abuse. PPI also conducts pre- and postpayment audits to identify potential overpayments and conducts medical record reviews.

Fraud Research Analytics and Concepts (FRAC) and Overpayment Solutions and Opportunities (OSO): Sub-units of CCM, FRAC, and OSO work in concert to conduct a variety of initiatives that proactively detect FWA.

FRAC, which we discuss below, and OSO use state-of-the-art software applications such as QlikView and Tableau dashboards to construct analytical, statistical, and predictive models that identify and detect FWA. We can focus these models on specialty or type of services we consider high risk. We select data based upon detailed investigation and research into potential fraud schemes and use data mining analysis to identify data markers that potentially indicate FWA, including outlier analysis, rules-based anomaly detection, trend analysis, and statistical analysis.

Additional CCM units:
- The **Risk Adjustment Integrity Unit** is responsible for investigating instances of FWA in Humana's provider network that impact risk adjustment submissions.
- The **Coordination of Benefits Unit** proactively coordinates benefits for Enrollees where there is another payer or Centers for Medicare and Medicaid Services (CMS) is the primary payer.
- The **Subrogation and Other Third-Party Liability Unit** identifies, investigates, and conducts payment coordination with third-party liability holders.
- **CCM Provider Support Services team** answers initial inquiries through a variety of methods, including online tools, phone, email, and correspondence. This team's mission is to make it easy for our providers to obtain the timely support they need by offering a simple, reliable, and personalized experience.
- **CCM Market Liaison team** focuses on provider engagement and key providers along with critical issue mitigation, settlement navigation, and oversight and resolution of Contract issues.
- **CCM Compliance team** partners with CCM's other business units, Regulatory Compliance, and other compliance teams throughout Humana. This team compiles and tracks FWA reporting to federal and State agencies and responds to requests for information from government and law enforcement agencies related to FWA.

Regulatory Compliance (RC): RC is responsible for overseeing the operational and administrative effectiveness of Humana's compliance program. Through an effective system of routine monitoring, auditing, and identification of compliance risks, RC can effectively monitor FWA activities and adherence to State and federal requirements.

a.	Provide a detailed summary of Contractor's proposed Program Integrity plan, including a discussion of the following:

Program Integrity Plan, a Component of our Compliance Plan: We detail our FWA efforts in our FWA policies, procedures, and Compliance Plan, which incorporates our Program Integrity Plan (i.e., Anti-Fraud Plan) and describes our mechanisms to prevent and correct fraud risk events. Our Compliance Plan clearly delineates our expectations for our associates and Subcontractors and mandates annual training for all providers, associates, and material Subcontractors. After incorporating the HHS OIG guidance, we structured our Compliance Plan to adhere to all relevant federal and State requirements, including contractual and regulatory requirements. Along with our Code of Conduct, our Compliance Plan incorporates the requirements set forth in applicable federal and Kentucky anti-fraud laws, regulations, and policies and specifically describes:
- Written policies and procedures for investigating and reporting FWA, including reporting overpayments to the Department of Overpayments and referrals to the Kentucky Medicaid Fraud Control Unit, DMS, and other State and federal agencies
- Clear oversight exercised by Compliance Officers and Corporate Compliance Committee across the organization
- Mandatory training and education for all associates, providers, and Subcontractors
- Effective lines of communication, including a well-publicized ethics hotline to report violations, an ethics helpline for assistance and questions, and multiple ways to anonymously report suspected FWA and ethics violations, including via our website, call centers, and ethics hotline

- Well-publicized disciplinary standards and strong enforcement mechanisms, including termination of employment or contracts for violations of our FWA policies and procedures, including our Standards of Conduct
- Routine monitoring and auditing to prevent and detect FWA, including service patterns for providers, Subcontractors, and Enrollees; random claims payment reviews; and code and payment edits
- Policies and procedures for prompt response to compliance issues

Program Integrity Plan: Our Program Integrity Plan (i.e., Anti-Fraud Plan), which is outlined in our Compliance Plan, articulates Humana's strategic efforts to detect FWA internally and amongst our providers and subcontractors. Humana's CCM is responsible for detection, prevention, and recommending process improvements for health insurance and prescription FWA. To help with this effort, Humana has established SIU offices in Kentucky, Florida, and Wisconsin and has SIU associates located in several states. Our Program Integrity Plan outlines SIU's goals, which include:

- Maintaining an anti-fraud program to protect Humana and government funds from potential fraud
- Conducting thorough and effective investigations into alleged fraud or abuse
- Educating providers regarding billing and documentation errors identified during the course of investigations
- Implementing pharmacy restrictions for Enrollees in accordance with federal and State regulation and Humana policy
- Recommending to terminate Humana's contractual arrangements with providers, agents, brokers, Enrollees, and other business entities when appropriate
- Recovering or denying payment for claims deemed to be fraudulent or inappropriately billed
- Reporting suspected fraudulent acts to the appropriate federal or State government agency or law enforcement agency, as required
- Cooperating, if requested, with federal or State officials in civil or criminal matters as a witness for Humana and/or attesting to the validity of information provided by Humana
- Training Humana associates in detecting, preventing, and reporting suspected fraudulent activities

Our SIU Director, David Popik, is accountable for our Anti-Fraud Plan and responsible for ensuring we modify it to address the requirements of the Draft Medicaid Contract. We detail SIU's efforts in our Program Integrity Plan, which is summarized below.

Relevant Statutes, Regulations, and Policies: The Program Integrity Plan provides a summary of applicable laws and policies. The plan includes summaries of the following:

- False Claims Act (FCA) – 31 (U.S.C.) 3729-3733
- Qui Tam Actions (31 U.S.C. § 3730(b)(1))
- Whistleblower Protection – (31 SC 3730 (h))
- Anti-Kickback Statute (AKS) – 42 U.S.C. 1320a-7b
- Stark (Physician Self-Referral) Law – 42 U.S.C. 1395nn
- Health Insurance Portability and Accountability Act (HIPAA)
- Deficit Reduction Act
- Red Flag Rules

Prevention: Prevention is central to Humana's Program Integrity Plan. Examples of the controls that the plan describes for preventing FWA include:

- Mandatory Standards of Conduct that apply to all associates, Subcontractors, Enrollees, and providers
- Subcontractor and provider contract provisions that define FWA and Humana's expectations with respect to preventing, detecting, and reporting FWA
- Provisions of the Provider Manual and Enrollee Handbook describing resources for Enrollees and Providers concerning FWA and reporting of suspected FWA

- Prior authorizations (PA) and Utilization Management (UM) procedures to ensure services are necessary and appropriate

Training and Education: Our Program Integrity Plan describes in detail our training plan for our associates, providers, and Subcontractors (including the Subcontractors' employees providing services to Humana), as well as Enrollee FWA education. All providers, associates, and Subcontractors must complete FWA training within 30 days of starting their relationship with Humana and annually thereafter.

Detection: Humana's FRAC conducts a variety of initiatives to proactively detect FWA. The Program Integrity Plan describes the data we review, the types of reviews we conduct (e.g., monitoring of provider and Subcontractor services patterns, use of code and payment edits, random claims payment reviews, and routine validation of data and service provision). The Plan also describes FRAC's data mining efforts including outlier, statistical and trend analysis, anomaly detection, and rules based anomaly detection. FRAC associates refer suspected cases of FWA to the SIU through the case tracking system (FIT) for triage review.

Investigation Process: The SIU's Triage Team conducts an initial investigation of referrals to determine the priority level of the referral and gather and analyze applicable case information. The Triage team reviews things such as public records, State licensure and the OIG exclusions lists, whether a previous SIU investigation occurred, and information about Humana's contract with the provider (e.g., participating versus non-participating, risk versus non-risk, etc.). The Triage team assesses the referral within two weeks of receipt to determine if the allegation involves fraud and abuse and if it meets the basic parameters for investigation by our SIU. Upon completion, the Triage team investigator either refers the case to an SIU investigator for further action or closes the case, which requires approval of SIU leadership. In 2019, the Triage team completed approximately 17,000 referrals using these procedures. Our Program Integrity Plan describes the SIU's full investigative process, along with the factors the SIU uses to review the cases.

Definitions and Examples: The Program Integrity Plan includes detailed definitions of types of fraud (e.g., associate fraud, Enrollee fraud, medical identify theft, etc.), along with examples to allow associates, providers, Enrollees and our State partners to use this plan as a resource.

Internal Collaboration: Humana, including CCM and the SIU, collaborates actively with internal departments and external organizations to identify new and emerging areas of FWA, complete a review/investigation, and report any findings we may have on allegations that come to our attention. We collaborate with other departments and agencies to ensure compliance in our reporting, provide education, gather information that may help our investigations, and share information with other areas when impacted by our investigations. We describe these collaboration efforts and common partners in the Program Integrity Plan.

Fraud Referrals to Government Agencies: The SIU is responsible for the coordination of referrals to law enforcement and government agencies as well as appropriate follow up on these referrals. Our SIU works with the appropriate departments within Humana to provide the maximum possible assistance to law enforcement and government agencies, including CMS and DMS, in compliance with State and federal laws. We have included details about our reporting and referral procedures in the Program Integrity Plan.

Continuously Improving our FWA Efforts: FWA prevention and detection is not static. We continuously work to improve our FWA prevention and detection efforts by updating our protocols, data analytics and algorithms, and identifying collaboration efforts.

- New and Emerging Areas of FWA: In 2019, Humana's SIU Director, David Popik, **created a new team, the Fraud Response Team, to proactively identify new and emerging areas of FWA.** The team is comprised of senior investigators with a highly-specialized skill set including investigators with experience with state Medicaid Fraud Control Units (MFCU) and the Federal Bureau of Investigation (FBI). The Fraud Response Team coordinates closely with FRAC to identify and mine data elements to create new processes and address new and emerging areas of FWA. While their work includes both pre- and postpayment activities, it has resulted in changes to prepayment edits and reviews. As a result of the Fraud Response Team's work,

Humana utilizes a new process to review non-participating providers who submit claims, our Non-Participating Provider Verification Process (PPG), to identify phantom providers. They have also identified new prepayment processes to address schemes related to telehealth providers to identify improper telesolicitation schemes and examine medical necessity determinations in genetic testing, mail order pharmacies (e.g., compounds for foot creams), and durable medical equipment (DME) (e.g., back braces, etc.) particularly from providers outside of the country.

- <u>Cross-Functional Collaboration</u>: For example, because fraud increasingly includes a cyber-component, we have established a structured collaboration between FRAC and our Cyber Hunting Analytics Response Team (CHART). CHART conducts vector assessments of incursions into our systems and builds threat profiles and day-to-day threat assessments. Our experience has taught us that these incursions may be indicators of a wider fraud scheme. To combat this, FRAC and CHART identify high-risk outliers for each of their teams to build into their algorithms that include:
  - o Protected or confidential Information, including anything that impacts Enrollee personal health information (PHI)
  - o Foreign involvement or ownership in provider organizations
  - o Header data (e.g., certain indicators in the headers of software data that indicate provider fraud)

Today, if CHART identifies a threat, it sends alerts to FRAC, the SIU, and other groups such as our Privacy Office. Similarly, FRAC alerts CHART when it finds a threat with a potential non-healthcare impact (e.g., banking fraud) or if FRAC's analytics find anomalies so that each team adjusts their algorithms.

a.i.	The Contractor's fraud and abuse detection/ prevention program activities for employees, caregivers and providers, including reporting and follow-up, continuous monitoring of compliance, identification and reporting of issues to all required parties, and ongoing training.

Based on more than 50 years of experience in providing managed care services, Humana has built specialized platforms and consolidates various data points in multiple ways in order to identify FWA at every service provider level and at each interaction an Enrollee has with the healthcare system. We have built our approach upon our groundbreaking analytical software to monitor data. Humana utilizes state-of-the-art software applications to construct analytical,

> In 2019, our SIU investigated **249 cases** related to Kentucky Medicaid.

statistical, and predictive models that identify and detect FWA. Humana's data mining analysis identifies data markers that indicate FWA. We use these tools and applications to detect all types of FWA, including provider and Enrollee fraud.

CCM's top audits primarily focus on billing and coding errors, coordination of benefits issues, contracting updates/issues, and validation using medical record reviews.

FWA Prevention: Our Anti-Fraud Plan is the foundation of our FWA prevention activities. It outlines our extensive training activities aimed at educating our associates, providers, and Subcontractors about FWA and how to prevent it. However, education is only the first step. Data collection is key to preventing FWA. FRAC runs algorithms daily so that questionable or suspicious claims are flagged and identified for further review to prevent erroneous transactions and inappropriate payments. Our extensive, structured ERM framework also emphasizes our culture of compliance and risk mitigation in an effort to prevent all types of waste and abuse.

We also recognize that FWA is ever evolving, which requires us to adjust our prevention efforts. This includes steps such as modifying our training programs, adjusting our detection algorithms, collaborating in new ways to learn from our associates, Subcontractors, and other stakeholders, such as our State partners, federal partners,

and other MCOs. Our associates and leadership participate actively in countless anti-fraud workgroups and task forces to identify emerging areas of risk and adjust accordingly to prevent FWA.

As FWA has become more complex, transparency has become increasingly important to prevention efforts. Transparency in claims processing is essential to reducing provider friction and increasing cooperation in FWA prevention efforts. Clearly articulated policies, procedures, and processes allow providers to comply with our requirements and foster a collaborative and communicative relationship. Similarly, transparency in our data collection and reporting fosters strong relationships with our State partners, including DMS, that in turn increases opportunities to identify ways to prevent FWA both for Humana and for the Kentucky MMC program more broadly.

FWA Detection: A unique aspect of our FWA program is our aggressive efforts to proactively detect areas of FWA, specifically provider FWA, using data mining and analytics to detect new areas of FWA risk as they emerge. Our FRAC team uses proprietary software applications and systems to construct analytical, statistical, and predictive models focused on provider specialty or types of services. For example, Humana currently uses a proprietary data-mining program that specifically targets pharmacy issues to detect areas of risk related to these services, such as overutilization or suspicious prescribing patterns. We select data to analyze based on detailed investigation and research into potential fraud schemes impacting various models. We process large amounts of data rapidly to identify unusual or suspicious billing patterns that warrant further investigation based on outlier, trend, and other statistical analysis, coupled with anomaly detection.

Investigations: The SIU is Humana's primary investigative department, with the Risk Adjustment Integrity Unit (RAIU) being another. The SIU investigates all types of FWA, including employee, Enrollee, and provider FWA. The SIU's associates have varied expertise including data analytics, clinical credentials, and investigative training and certification and many of them have past experience in law enforcement. **In addition, the SIU is also supported by a dedicated clinical team of approximately 80 clinicians**. The SIU's thorough investigation protocol includes onsite reviews as well as reviews including claims data analysis, medical records review, expert review, provider/provider staff interviews, law enforcement collaboration, Enrollee interviews, information-sharing with appropriate entities, etc.

Figure I.C.26-1: Program Integrity Model

FRAUD, WASTE, AND ABUSE IDENTIFICATION PROCESS

INNOVATE — Identify new audit opportunities through partnerships and data mining

PROTOTYPE — Build, test and validate audit concepts through collaboration and iteration

OPERATIONALIZE — Audit results and pursue savings opportunities

RESOLVE — Utilize our customer service team to respond to provider questions

FINALIZE — Collect and post overpayments, reconciling results with claims system

IF WE BELIEVE THE PROVIDER IS POTENTIALLY CAUSING HABITUAL FWA OUR SIU TEAM REVIEWS

SPECIAL INVESTIGATIONS UNIT

DETECT — Leverage data mining and referrals, identifying potential fraud investigations

ANALYZE — Utilize triage investigators to analyze leads and open cases when appropriate

INVESTIGATE — Gather evidence to prove or disprove the fraud allegations

RESOLVE — Pursue recovery opportunities and make government referrals

FINALIZE — Stake corrective action, finalize recoveries and close investigations

Preventing and Detecting Employee Fraud and Abuse: Before extending an offer of employment, we carefully screen prospective associates for eligibility to participate in a federal or State healthcare benefit program. Upon hire, we require that all associates complete and attest to mandatory FWA training within 30 days of beginning employment and annually thereafter. This requirement applies to all Humana associates, including our CEO Bruce Broussard, all senior leaders, and the Board of Directors. The Corporate Learning Center tracks completion of the training and automatically turns off access to Humana systems for anyone who fails to complete the training. Our associate intranet enables easy access to our Ethics Every Day training, which associates and contractors can use as a resource. Content includes:

- Our comprehensive Code of Conduct and a description of our Compliance and Anti-Fraud plans
- A description of applicable FWA laws, regulations, and requirements
- Information on how associates can report suspected cases of FWA
- Whistleblower protections for anyone who reports FWA

We tailor our training to Kentucky requirements and will modify our existing training to incorporate Draft Medicaid Contract requirements, as well as any changes to Kentucky laws, regulations, and DMS/Medicaid Fraud Control Units (MFCU) policies. We have additional specialized training for CCM/SIU associates; for example, our SIU has extensive two-phased training designed to specifically address its functions, processes, and applicable requirements. Supplemental training by the SIU is also available upon request. Along with our structured annual training, we use several methods to provide information and training throughout the year. For example, we update our intranet home page daily, which regularly includes topics related to FWA and other compliance topics. Associates also receive emails highlighting specific topics and updates.

We have a comprehensive and structured oversight and monitoring program that involves a multi-layered, local-corporate approach to managing risk, including employee FWA. Our ERM program applies a comprehensive process to all lines of business and departments and includes a focus on fraud as an element of operational risk. This model formalizes a process for identifying areas where associates are responsible for identifying areas where there may be not only fraud but also waste and abuse. Associates enter these identified risks in our Enterprise Solution Point (ESP) tool, where associates and managers track their risks and update the status of remediation activities. The ESP platform contains a series of interconnected solutions, each with the goal of assuring that the most efficient and effective risk and compliance solutions are in place and visible to our managers and leadership. This risk management process and sophisticated tracking in ESP allow for transparency across our operations.

For employees suspected of potential activity involving FWA, the SIU investigates associates in the same manner as it does other cases of suspected FWA. Our SIU opens a case, assigns an investigator, and tracks the case in our proprietary tool, FIT. Our Human Resources (HR) department reviews employees suspected of other types of fraud or abuse not involving healthcare, such as suspected identity theft cases, in conjunction with our Enterprise Investigations Consortium (EIC), an enterprise-wide body made up of numerous investigatory or supporting departments with experience or interest in potential FWA. All cases are thoroughly investigated by the appropriate department with the assistance of Legal, HR, the SIU, and the Corporate Compliance departments, with external and internal reporting of findings as appropriate. If an investigation validates an employee issue, we follow published disciplinary guidelines.

Preventing and Detecting Caregiver Fraud and Abuse: Enrollees and caregivers are often the first to identify or notice cases of FWA. We actively engage Enrollees and their caregivers in preventing two types of FWA:

- FWA committed with or by the Enrollee (such as submitting false claims, doctor shopping, altering bills, identity theft, or letting someone else use the Enrollee's ID number)
- FWA committed by others [such as providers, Care Managers (CMs), or transportation vendors]

We specifically incorporate Enrollees and caregivers into our Anti-Fraud Plan and educate them through various channels. For example, we educate Enrollees about improper card sharing and our procedures for detecting and reporting such instances. Our Enrollee Handbook includes information about FWA prevention and reporting. Our

website features information about FWA and how to contact Humana to report a suspected violation. For Enrollees who receive Smart Summaries, we include FWA information on the summaries, with directions on how they and their caregivers can contact Humana to report discrepancies. Similarly, in accordance with our established policies and procedures, SIU specialists engage Enrollees and caregivers to conduct service verification. SIU specialists use our data warehouse to randomly select Enrollees who have received services and send letters verifying the service, ensuring that the sample is stratified so all provider and claim types are represented.

For Enrollees or caregivers who want to contact us for information, provide a tip, or report a suspected violation, we have a dedicated email address that we check daily, as well as a dedicated toll-free hotline. Our MSRs will also take these calls, and our Interactive Voice Response (IVR) system is configured to support Enrollee tips. This information is available in our Enrollee Handbook and on our website.

Our CMs are actively involved with Enrollees and strive to establish a strong relationship. We train CMs to identify potential cases of abuse or neglect of children, elderly Enrollees, and Enrollees with special needs. CMs are trained to report any allegation that involves the potential that an Enrollee is under threat or being abused and if appropriate, initiate a referral to child protective services, law enforcement, adult protective services, or another appropriate protective agency or entity. We consider all cases of Enrollee abuse a priority and quickly obtain information from all departments to evaluate the allegation and take immediate action to address the incident.

Preventing and Detecting Provider Fraud and Abuse: Provider cases represent the majority of FWA cases. Extensive provider training is the first step in preventing provider FWA. We require providers to complete orientation upon inclusion in our network, which includes extensive information about FWA prevention and detection. Providers also receive ongoing training through numerous channels, including newsletters, alerts, and one-on-one training from their Provider Relations representative. We also use data analytics to identify areas or patterns that put providers at risk for FWA; our CCM associates conduct targeted training to address those patterns or practices.

To detect provider FWA, Humana has developed data analytic models focused on a provider specialty. These models look for numerous potential red flags for a provider. If we look at each red flag individually, many times it is not strong enough to indicate potential FWA. However, when we run the provider's claims through the data model, we review them from all angles and discover all potential red flags. This view provides the evidence needed to indicate potential FWA. Humana uses these tools to refer potential FWA to the SIU for review, investigation, and referral (if appropriate).

Case Example:
Using data analytics, our SIU identified a clinical laboratory billing for high levels of urine drug testing and pharmacogenetic testing. Through Enrollee and provider interviews and medical records review, the SIU found that the laboratory was also accepting orders for genetic testing from a suspected conglomerate of entities representing themselves as telemedicine providers. Our research indicated these telemedicine providers hired physicians via an online placement agency and instructed them to write orders for genetic testing, DME, and pain creams based solely upon review of patient medical records created by an employee of the telemedicine company. After building a case, we terminated the provider and referred the case to the appropriate State and federal agencies for follow up and prosecution.

We also use multiple methods to verify services have been delivered to Enrollees. For example, our SIU may use electronic visit verification (EVV) to verify visits and the services provided during those visits to safeguard against

inappropriate billing and FWA. For example, in one of our other Medicaid markets, CMs provide information about missed visits through the EVV, and the CCM or SIU compares this information against claims data to ensure appropriate billing occurred. In our Florida Medicaid plan we have an EVV Data Usage Steering Committee that explores ways EVV data can be used and improved.

In accordance with our established policies and procedures, SIU specialists engage Enrollees to conduct service verification. **The SIU specialists use our data warehouse to randomly select, ensuring that the sample is stratified so that all provider and claim types are represented, at least 500 Enrollees (from claims data) who have received services and send letters verifying the service**.

Identification and Reporting to all Required Parties
The SIU investigates fraud at all levels from Subcontractors, providers, Enrollees, and associates. Our SIU uses extensive expertise and tools to examine allegations of fraud or abuse. Among these are the innovative approach to proactive fraud detection through our FRAC, as well as an internally-built, state-of-the-art case management system, FIT, and a dedicated clinical team to provide clinical guidance on investigations when needed. For all new referrals, Humana's SIU conducts an initial review to determine:

- If a reasonable inquiry should be initiated, at which time the referral will be opened as a case and assigned to an investigator for a further investigation
- If a provider should be placed on a watch list
- If the referral should be closed with education provided to the individual who submitted the referral
- If the referral should be closed with no further action

Each referral and case is inherently unique. However, SIU investigators often employ similar investigative techniques to complete a case review. SIU's investigative techniques include, but are not limited to:

- Verifying the allegation validates a reasonable inquiry to be opened
- Conducting onsite visits to review information
- Reviewing medical, dental, and/or pharmacy claim information
- Interviewing Enrollees' providers and/or pharmacies
- Requesting and reviewing copies of medical or dental records from providers or prescriptions/signature logs from pharmacies
- Sending and reviewing Enrollee questionnaires or prescription verification letters
- Researching non-Humana resources (e.g., Internet resources)

As the case progresses, we document the investigative steps in the appropriate activity in FIT and attach electronic copies of all documents pertaining to the case. The SIU can view details of relevant case documentation extract them from the Electronic Data Warehouse (EDW) for reporting. If the SIU Triage team does not open a case upon reviewing a new referral, it documents the reason(s) and rejects the referral, storing it in FIT for future retrieval if needed.

When warranted, the SIU collaborates on investigations with law enforcement at the federal, State, and local levels. The SIU reports any suspected or confirmed fraud or abuse regarding Kentucky Medicaid in accordance with the reporting requirements found in Sections 36.1 and 36.3 of the Draft Medicaid Contract, after review and approval of confirmed suspicion of FWA from our internal Government Referral Panel.

Dedicated Teams for Specialized Functions: Our experience with specific risks associated with particular Medicaid services or types of providers led us to develop dedicated teams that follow targeted procedures for monitoring providers and Subcontractors. For example, we have specialized focus in areas such as behavioral health (BH), pharmacy services, and transportation. The Pharmacy Fraud, Waste, and Abuse & Prevention team monitors and audits the pharmacy network to prevent FWA, promotes appropriate claims processing according to Humana and CMS guidelines, and corrects overpayment and underpayment of claims. **Across Humana we conduct a minimum of 5,000 pharmacy desktop audits annually**.

Government Referral Panel (GRP): To ensure consistency and a fair and proper review of all investigations, Humana established the GRP to review all cases that the SIU or another department determines is potentially reportable to the State or other regulatory body. This panel was created to consider cases and ensure that criteria are met to refer a case on to the appropriate government agency. This is an innovative approach to streamline and operate efficiently in referring cases appropriately, which enables Humana, DMS, and other agencies to pursue cases with merit. Investigators will present their cases to the GRP once a case meets one of the following milestones:

- Completed postpay audit that resulted in findings
- Confirmation of multiple instances of services not rendered
- Referral was received from a government agency, and Humana's Medicaid exposure fits within the scope of that allegation
- Any indication that the provider is a phantom provider
- Other evidence gathered indicates a credible allegation of fraud

The GRP ensures the case has been properly investigated and the referral has clear language, meets the relevant requirements for referral, and is consistent with best practices. As a result, this process produces quality referrals for Kentucky's Medicaid Program Integrity unit, and we are better able to send directly to the Medicaid Fraud Control Unit (MFCU), offering more actionable information and additional details to support next steps. This process ensures that investigators' time is not wasted reviewing referrals that are unsubstantiated or not an FWA issue.

Enterprise Investigations Consortium (EIC): The EIC, which supports Humana's SIU, provides a big picture view of our investigative functions across our organization so that we can identify areas of collaboration and ensure that we maximize our knowledge and effectiveness.

Ongoing Training
Humana requires all associates, Subcontractors, and providers to complete Program Integrity training within 30 days of beginning employment and annually thereafter. Failure to complete this training will automatically result in the associate/Subcontractor being locked out of Humana's systems.

Similar to the initial training, annual training includes completion of an Ethics and Compliance Training module, which the SIU team developed to promote appropriate identification and reporting of FWA. We track and record completion of this online training module, which includes the following topics:

- Effective Lines of Communication
- Monitoring and Auditing
- Standards of Conduct
- Compliance and FWA Training
- Conflict of Interest
- Response to Detected Offenses
- Disciplinary Guidelines
- FWA, including the False Claims Act
- Policies and Procedures
- How to Report both Compliance and FWA Concerns
- Whistleblower Protections

Additional resources related to Program Integrity are available for associates and Subcontractors on our website and intranet.

Along with mandatory annual refresher FWA training that Humana or the provider's office conducts, our CCM or Provider Relations representatives conduct additional training when there are changes in Medicaid programmatic requirements; FWA requirements; or Humana policies, procedures, or requirements or when our data analytics, CCM, PPI, SIU, or the ERM team identifies an issue. There are also extensive resources and additional trainings available to providers through our provider portal, Availity. We also train providers on FWA through articles in newsletters issued quarterly, information included in the annually-issued Enrollee Handbook, in the Provider Manual, and via continuous updates on our website. Through these distribution vehicles, providers also become educated on activities prohibited by the False Claims Act, including whistleblower protections and prohibited affiliations. Finally, CCM has a team that focuses on provider education and billing

practices. This team performs targeted training to specific providers who have a large volume of overpayments in a category. It is designed to provide the specific materials and necessary support to improve providers' billing behavior and reduce potential FWA and overpayments.

a.ii.	An overview of the Regulatory Compliance Committee.

Humana has a multi-faceted regulatory framework that monitors compliance risks at each level of our Medicaid operations. Our fully dedicated Kentucky Medicaid CCO, Kimberly Myers, has more than seven years of Kentucky Medicaid compliance experience as well as Program Integrity, privacy and delegation oversight. Our CCO is part of our Regulatory Compliance (RC) department, which is responsible for overseeing the operational and administrative effectiveness of Humana's compliance program. Using an effective system of routine monitoring, auditing, and identification of compliance risks, RC can effectively monitor adherence to State and federal requirements. This system includes extensive risk-based assessments of key administrative and operational functions, internal monitoring and auditing, and, as appropriate, engagement of external monitoring and auditing to evaluate Humana's compliance with these requirements and the overall effectiveness of the compliance program. RC works closely with many internal departments (e.g., the SIU, Internal Audit Group, Organizational Risk Management, etc.) engaged in identifying compliance risks within Humana and our Subcontractors.

RC documents compliance deficiencies we identify and corrective actions taken in an online tracking tool, called Enterprise Solution Point (ESP). ESP is a state-of-the-art automated Governance Risk and Compliance tool, developed by Archer Technologies. It is a multi-layer tracking and accountability platform. In ESP, RC associates are able to track the applicable requirements, associates with responsibility for the requirements, and actions being taken to document compliance. Tracking in ESP also provides the opportunity for reporting to a broader audience via risk dashboards.

Associates from our RC department participate in our Medicaid Compliance Steering Committee. The Steering Committee is an operational oversight committee that meets monthly to monitor internal Medicaid compliance risks and report these risks to the Regulatory Compliance Committee. The Medicaid Integrated Compliance Scorecard drives the discussion, providing the opportunity to monitor and report on Medicaid compliance risks. The Medicaid Integrated Compliance Scorecard is compiled monthly by Operational Risk Management and is comprised of two parts: 1) a point-in-time assessment of compliance for each contract and 2) compliance metrics including current compliance measurements for the reporting month. The results are trended and provide a realistic view of business operations, taking into consideration normal and unusual occurrences. Discussion of the metrics facilitates the closure of external and internal Corrective Action Plans (CAP) and other notifications of non-compliance. The Medicaid Integrated Compliance Scorecard also facilitates the closure of external and internal CAPs and other notifications of non-compliance. We share scorecards, dashboards, and the results of the Regulatory Compliance Committee discussion with senior leaders across Humana, including our Corporate CCO, Sean O'Reilly, President of Medicare/Medicaid Operations, Alan Wheatley, Vice President of Medicaid, John Barger, and other senior leaders.

In addition to the Medicaid Integrated Compliance Scorecard, the Steering Committee discussions include the Metric Dashboard. Humana's monthly compliance dashboard displays performance on metrics using criteria that include the following considerations: criticality to key business processes, seasonality impact, and at-risk or under-performance for the reporting period. This monitoring tool allows Humana to get ahead of potential DMS compliance issues by gathering data across the following primary business functions: required reports, claims, clinical, Enrollee services, grievances and appeals, provider network, and reconciliation. We publish compliance scorecards and dashboards to senior leaders across Humana, including the CCO, COO, President of Medicare/Medicaid Operations, Vice President of Medicaid, and other senior leaders.

Another standing agenda item is High-Risk Implementations, which are any risks associated with a new regulation/Contract provision. As necessary, committee members identify any risks, barriers, or gaps that would impede timely implementation of the new regulation/Contract provision.

Along with the standing monthly meeting and metric reporting described above, Humana also produces regular reports for the Medicaid Compliance Steering Committee so that its members can get a thorough understanding of our operations by examining and ensuring compliance for specific areas, including but not limited to the following:

- Monthly reports of Enrollees and providers
- Monthly compliance reports
- Weekly compliance reports helping to confirm cases were closed in a timely manner in regards to the Medicaid Grievance and Appeals compliance regulations and programmatic requirements
- Daily open Critical Inquiry (CI) inventory summaries on open and pending statuses with their due dates, created dates, owner information, and more
- Bi-weekly DMS CI inventory reports that detail the inventory and reason code; management dealing with DMS Medicaid complaints, grievances and appeals; tracking all received cases for the year; and giving a summary of open and pending cases
- Weekly acknowledgement reports to determine which cases were acknowledged in a timely manner for Medicaid and Provider Grievances and Appeals in relation to Medicaid rules and programmatic requirements
- Discretionary payment reports giving the number of discretionary payments made, including the overturn amount and the reason

The Medicaid Compliance Steering Committee's work helps inform the efforts of the Regulatory Compliance Committee. The Humana Regulatory Compliance Committee meets monthly. It is chaired by the Medicare and Medicaid Compliance Officer and includes representatives from Compliance, Legal, Internal Audit, and Humana Medicaid Operations, among others. The purpose of the Regulatory Compliance Committee is to provide a forum to present, review, analyze, and make recommendations on issues pertaining to our Medicaid programs. The agenda includes discussion of pressing compliance issues in each Medicaid program, including Kentucky Medicaid. This oversight includes, but is not limited to:

- Developing strategies to promote compliance and the detection of any potential violations
- Reviewing and approving compliance training and ensuring that training and education are effective and appropriately completed
- Assisting with the creation and implementation of the compliance risk assessment and of the compliance monitoring and auditing work plans
- Assisting in the creation, implementation, and monitoring of effective corrective actions

The Regulatory Compliance Committee's recommendations, in turn, feed back to the process business owner, the Regulatory Compliance department, and the Medicaid Compliance Steering Committee, creating a closed loop of oversight and monitoring. The Regulatory Compliance Committee escalates high risk issues to the Corporate Compliance Committee for further review and oversight.

a.iii.	The proposed appeals process.

In accordance with Section 36.1.13 of the Draft Medicaid Contract, Humana has a well-established provider appeals process that includes clear policies and procedures, an avenue for providers to submit an appeal through our provider portal, Availity, and clear lines of accountability for associates responsible for resolving appeals.

We use multiple channels to inform providers about our appeals process. Upon entry into our network, all providers must participate in training that describes our appeals procedures. Providers may also access detailed information about these procedures in our Provider Manual, which is available to them in paper and electronic formats. They may also access this information through Availity. Finally, our Provider Relations Team and Provider Call Center Representatives educate providers about the appeals process and can assist providers in filing an appeal.

Our Provider Resolution team is highly trained and experienced and includes associates with specific areas of expertise, such as claims payment appeals and prepayment appeals, to resolve grievances and appeals accurately and expeditiously. **In 2018, the top five reasons for the appeals included prior authorizations, coordination of benefits, timely filing challenges, duplicate claims, and appeals that required consent forms**.

Tracking Appeals to Ensure Compliance: To ensure we respond thoroughly to each appeal, Humana's highly-trained Provider Resolution associates use an end-to-end tracking system built to process grievances and appeals consistently, within the State-mandated timeframes, and in compliance with Kentucky statutes and regulations. We have configured our proprietary Customer Relationship Management (CRM) system and inventory management tool, mhk, to comply with programmatic performance requirements, allowing us to track relevant deadlines, flag at-risk cases, and adhere to programmatic obligations while compiling a full and complete record. This enables our associates to respond to providers with the information necessary to understand our rationale and avoid future appeals.

Providers may use multiple channels to submit their appeal such as through our Provider Services Call Center, in writing, via email, or in person to their Provider Relations representative. Upon receipt of an appeal, it is logged by the associate receiving the appeal (e.g., Provider Relations representative, Provider Call Center representative, or Provider Resolution team associate) and automatically routed using our inventory management system. The inventory management system automatically assigns the appeal to an associate based upon the subject of the appeal and expertise of the Provider Resolution team.

The Provider Resolution team associate then works with subject matter experts at Humana, including associates with clinical expertise, CCM associates and associates in the PPI and SIU, to research and resolve the appeal. Upon resolution, the Provider Resolution team associate notifies the provider of the resolution decision. The Provider Resolution team associate also notifies the provider of their right to an independent external review in accordance with KRS 205.646 and 907 KAR 17:035, if applicable.

Appeals Related to Prepayment Reviews: Provider appeals that involve prepayment reviews, including prepayment reviews described in 907 KAR 1:671 and Section 36.2 of the Draft Medicaid Contract, are automatically routed to an associate in Humana's SIU through the inventory management system. An associate in the SIU Shared Services team reviews the appeal and the reason for the denial. For denials based on a clinical issue, the SIU associate consults with a clinician with relevant expertise. Following review and analysis, the individual performing the review develops a decision regarding the prepayment review decision. As described in Humana's Anti-Fraud Plan, policies and procedures, and Provider Manual, providers are entitled to an external independent third party review in accordance with KRS 205.646 for any appeals related to the prepayment process. The SIU associate notifies the provider of their decision regarding the prepayment review in accordance with DMS requirements informing the provider that they have 180 days to submit a request for an external appeal.

> As an active participant in NHCAA, Humana associates presented the case of United States vs. Nazanien Ebrahimi, which highlighted the intersection between healthcare fraud and other types of fraud, such as identify theft, banking, and credit card fraud – an increasingly common convergence of fraud and abuse.

Prepayment appeals outside of the parameters of 907 KAR 1:671 and Section 36.2 of the Draft Medicaid Contract (e.g., routine prepayment reviews) are assigned to a Provider Resolution team associate who will

coordinate with the Provider Payment Integrity unit based upon service level agreements (SLA). These types of prepayment reviews may be based on issues such as medical record reviews, billing and coding errors, medical necessity reviews, or level of care determinations. The Provider Resolution team associate and PPI associate will assemble a case file, render a decision, and notify the provider of resolution within 30 days. This resolution notice will include information about the provider's next level appeal rights, including how they may request an independent appeal review.

Monitoring and Oversight: Monitoring and oversight are central to our provider grievances and appeals system. Our cross-functional Provider 360 Committee exists to identify trends in provider appeals, recommend opportunities for improvement, and continuously improve our relationships with our providers. Chaired by our Provider Services leader, Mary Sanders, the committee includes market leadership and a combination of market and corporate support areas, including our Kentucky Medicaid CCO, Kimberly Myers, and associates and leaders from our Provider Relations, Claims Performance Management, Integrated Provider Solutions, and Provider Communications teams. The Provider 360 Committee meets monthly to discuss and analyze trend data, perform root cause analysis, and identify potential process improvements, including ways to improve our response to our providers' appeals.

a.iv.	Proposed innovations for reporting data in the Program Integrity area. Provide examples of successful innovations implemented in Kentucky or other states.

The purpose of a reporting package should be to ensure transparency and communication of information and analysis to drive actionable insights. The data should be more than numbers on a page and contribute to an effective oversight and monitoring process. Humana has thoughtful and dedicated leaders trained to analyze data, examine root causes, and engage teams cross-functionally to effectively prevent, detect, and respond to FWA. We believe DMS and its partners such the Kentucky MFCU can continue to achieve the success it has had by collaborating with the chosen Medicaid MCOs to identify improvement opportunities in its current report package as well as by adding additional reports to the package.

Humana's Leadership Role: Humana's CCM and SIU associates have long taken a leadership role in collaborating with our State partners to adjust reports and develop new reports that account for new types and sources of available data, changes in FWA threats, and to improve the usefulness of the reports for the State. These conversations ensure our understanding of the data sought and open lines of communication for process improvements.

Our SIU Director, David Popik, is an active member of the NHCAA Medicaid Fraud Workgroup, which one of their current focuses is on centralizing Program Integrity reporting data and allowing for use nationally. This workgroup includes top CMS and OIG officials, as well as key officials from health plans. This group is exploring opportunities to improve Program Integrity data collection and application and is discussing topics such as:
- Consistency, communication, and collaboration
- Formalized case coordination opportunities
- Recognition of preventive measures and how to track loss
- Incentives for MCOs to maximize anti-fraud efforts
- Standardized reporting across programs and plans

This workgroup is intended, in part, to promote collaboration between states and their partners. We recommend that upon completion of this workgroup's recommendations, DMS consider implementing the recommendations to the extent practical and feasible to promote consistency among the states, collaboration with the MCOs, and to allow for a deeper understanding of the risks and opportunities to prevent and detect FWA nationally.

Case Example:
During the fourth quarter of 2017, the Florida Medicaid agency [i.e., Agency for Health Care Administration (ACHA)] sought a new quarterly report to capture waste-related activities, including overpayments, in conjunction with the fraud and abuse quarterly report. The CCM Compliance team and PPI worked cooperatively with AHCA to determine which data to include on the report and how best to capture the necessary data in order to make the report effective and informative. We continue to partner with AHCA to ensure thorough and accurate reporting that reflects innovative opportunities.

Improving Current Reports: Humana is committed to being a transparent thought leader within the Program Integrity reporting space while bringing our values of **Re-Think Routine** and **Pioneer Simplicity**. Humana takes seriously our obligation to deliver accurate, timely, and actionable data to our State partners so that they may drive positive change in the healthcare system and align these outcomes to State agency goals. We believe that, along with adding innovative reports and analysis to the reporting requirements, there are also changes that can be made to the existing reports that will help DMS and its State partners such as MFCU, better analyze the information it currently collects to identify actionable improvements.

> We commit to establishing a portal for DMS to access agreed-upon components of our data directly.

Key to reporting that provides DMS with the information it needs to analyze health plans' performance is information that is transparent and comparable. In their current form, many of the reports lack specificity such that MCOs have a certain flexibility in how or what they report. There are also additional improvements that could be made to the existing reports including:

> In 2019, our SIU completed 57 Kentucky Medicaid reports with **100%** submitted on time.

- Adding data fields such as provider type would allow for analysis of trends by provider type.
- Eliminating redundancies in the current reports would improve efficiency. For example, MCOs report monthly on internal referrals (i.e., tips) but similar information is also reported on the quarterly report 76.

In addition to these overarching recommendations, we recommend that DMS consider adding an additional element to report 66 that identifies the dollars at issue in cases where DMS or other Kentucky Program Integrity and enforcement agencies request we stop pursuing a case. We recommend this report include a brief description of the issue and the dollars at issue so that DMS can analyze the types of cases that were not pursued and whether pursuing the cases would have been a cost-effective use of resources.

Revisions of an existing reporting package may seem like a large undertaking; however, Humana is excited to assist with this process and be a partner with DMS to ensure reports help drive actionable insights and outcomes. We are committed to continue partnering with DMS and believe there are multiple opportunities to leverage our experience in other Medicaid programs – and that of the other MCOs – as well as our expertise in other types of health benefit programs, such as Medicare, to identify improvements. For example, we would be willing to complete an analysis of DMS's current Program Integrity reports as compared to those of other states to determine whether there are additional or different data that DMS might be interested in collecting. We also suggest DMS consider creating or participating in a work group of MMC plan staff to work collaboratively with DMS in identifying Program Integrity reporting improvement opportunities, such as ways to improve consistency across the plans.

## PROPOSED INNOVATIONS IN DATA REPORTING

Proposed Innovation: Introduce Dashboard Reporting

Dashboards centralize data so that users can interact with and analyze the most up-to-date information. This leads to smarter, faster, data-driven decision-making. Because dashboards are customizable, users can use dashboards to drill down on data elements while also performing trend analysis to make decisions. **In our experience, states are increasingly using dashboards, particularly in the Program Integrity area where there are large amounts of data to be analyzed**.

██ including dashboards based on specialty such as behavioral health or services such as pharmacy. For example, we currently use our CCM Compliance Medicaid dashboards internally to analyze our operations and share this with our State partners in other State Medicaid programs, summarizing Medicaid-specific SIU cases to identify trends unique to Medicaid. These dashboards include data such as referrals to SIU, cases being investigated, number of referrals transferred to an investigator, average number of days a case is open, how long a case is in triage (case aging), and reasons for closing a case. We share these dashboards with the Corporate Compliance Committee on a quarterly basis so that they are better able to monitor unique Medicaid risks. An example of one of these dashboards is included below in **Figure I.C.26-2**.

CCM utilizes two specific dashboards for Kentucky Medicaid Program Integrity: 1) Tableau, which includes Kentucky Medicaid claims data across multiple years, and 2) QlikView. Please see the figure below for an example of a dashboard screenshot.

Figure I.C.26-2 CCM Compliance Team Governance Referrals Dashboard
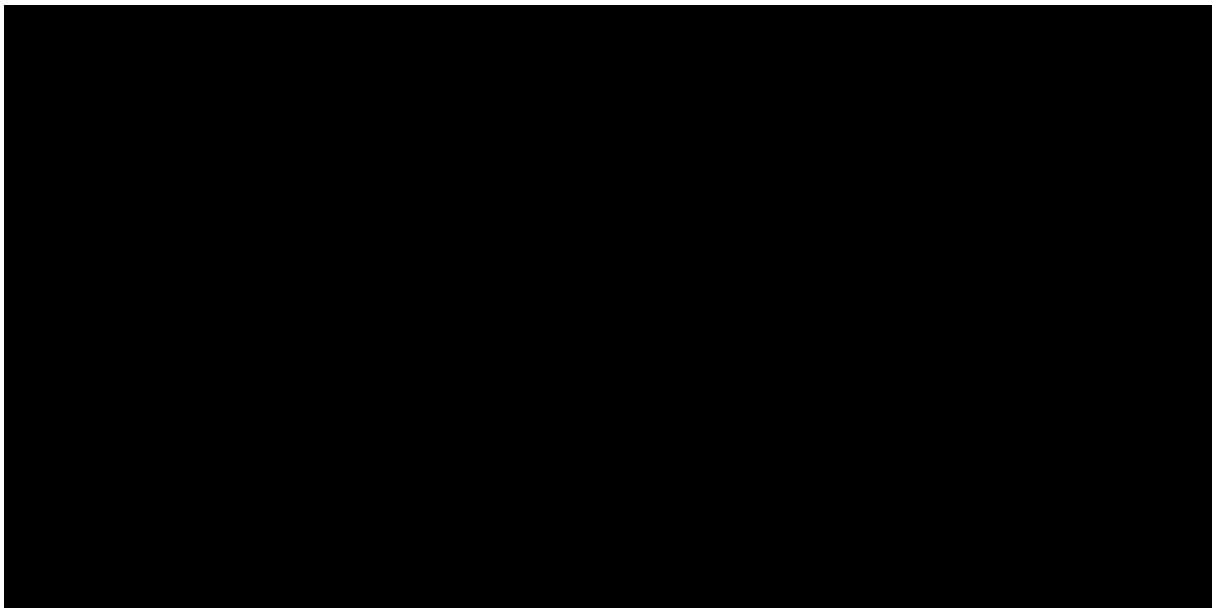
Dashboards provide a 360 view regarding specific claims along with information on provider data, demographics, and distance data, so we can identify anomalies. For example, Humana's provider network includes providers in bordering states to serve Enrollees. These dashboards allow CCM associates to quickly flag outliers such as out-of-state providers whose locations are out of a typical travel distance for our Enrollees; for example, hospitals located near the Kentucky-Ohio border, such as Cincinnati Children's Hospital, would be logical option for Enrollees due to its proximity.

Proposed Innovative Reports

Telehealth Report: Telehealth is an innovative service health plans are using to address Enrollee gaps in care resulting from access barriers. Providers are also increasingly turning to other telehealth providers for consultation, support, and referrals. In Humana's experience, this has led to new and emerging fraud schemes

that we have identified through our algorithms, data mining, and analysis. For example, telesolicitation, including "cold calling," or telehealth providers' participation in health fairs has resulted in questionable referrals and testing. This is particularly true in the area of genetic testing where the telehealth providers solicit or encourage inappropriate or unnecessary genetic tests. We recommend that DMS develop and implement a new report that looks at telehealth services differently from the current report (#31), which focuses on cost and reimbursement issues. This new report should collect data on referring physicians, telehealth service providers, and the services provided, including location of the service, demographic information, identifying information about the providers [e.g., National Provider Identifiers (NPI), licenses, etc.] and the volume of referrals by provider type.

Non-Participating Provider Reporting: In 2019, Humana's Fraud Response Team developed a new process that examines our non-participating provider verification process (PPG). At a high level, this process utilizes multiple data sources to determine if the non-par provider is, in fact, a legitimate healthcare provider. This reporting, analysis, and investigation project demonstrated that the biggest areas of risk are primarily:

- DME providers
- Laboratory providers, particularly genetic testing providers
- Non-Emergency Medical Transportation (NEMT) transportation
- Home health providers without a recent claims history (if new or haven't received claim in last 2 years)

We recommend that DMS require a report that collects data regarding this emerging area of FWA. The report should include information about non-participating providers including identifying information about the provider (e.g., NPIs being billed, license number(s), etc.), the names of the organization's senior officers and billing manager, and the claims being billed, at a minimum. This information can be used to analyze the patterns of fraud and to better inform DMS, other State agencies such MFCU, and the other MCOs.

Electronic Visit Verification: Electronic visit verification (EVV) provides a powerful new tool in MCOs' fraud detection efforts. For example, in our Florida Medicaid program, we are actively exploring the ways that we are able to collect and analyze data resulting from EVV implementation, including through our existing EVV Data Usage Steering Committee. To capture this information for its analysis, we suggest that DMS add a monthly report that require MCOs to provide data about EVV visits, the services being provided through those visits, location information, and services missed.

Value-Based Provider Fraud Risk Identification Report: To address this emerging area of FWA, we recommend that DMS begin monitoring risk based arrangements as we anticipate growth in these models in Kentucky's MMC program. We suggest DMS consider developing capabilities including data and analysis of provider behavior to identify outliers indicating potential fraud (e.g., analysis by condition or diagnosis compared to diagnostic tests, pharmacy usage, or DME). We recommend DMS collaborate with its managed care plans to develop these capabilities to ensure that they are broad enough to encompass the various value-based payment arrangements in Kentucky while being detailed enough to identify outliers in a manner that is sufficient to measure and identify the appropriate response.

Future Innovations in Reporting Data
From our internal perspective, we anticipate that the ongoing collaboration with FRAC, cybersecurity, and the SIU will lead to innovative reporting opportunities currently not in existence in the Commonwealth. Specifically, we believe there are areas at the intersection of healthcare FWA and various other types of fraud (e.g., identify theft, credit card theft, banking fraud, etc.) that will lead to additional data collection, detection, investigation, and reporting opportunities. We commit to collaborating with DMS to establish these requirements and determine the best way to capture the most relevant and accurate data that DMS, MFCU, and potentially other MCOs can use to improve prevention and detection efforts.

b.	Describe the Contractor's proposed approach to prepayment reviews.

Humana has a multi-pronged approach to prepayment reviews. This approach combines multiple automated tools and platforms that identify potential waste and abuse and prevents payments for those claims. Our Provider Payment Integrity (PPI) unit also conducts multiple types of reviews and audits that also detect and prevent overpayments or improper payments. █████████████████████████████████████ ██.

The PPI unit's approach with respect to pre- and postpayment reviews is to move as many postpayment reviews to prepayment edits in an effort to reduce provider abrasion and reduce the need for provider recovery collections as much as possible. To achieve this, we have developed a tool, Total Humana Overpayment Resolution (THOR), to reduce the need for provider recoveries on postpay. THOR systematically enhances our Claims Adjudication System (CAS) algorithms to allow for better, more complex rule-building. Through these enhancements we can expand our criteria and call-outs to our other claims-integrated systems, which means we can review more claims on a prepayment basis. Moving more rules to prepayment enables us to improve the provider experience by paying claims right the first time. THOR uses a cycle approach: The tool flags a postpayment rule and then develops new prepayment logic based on the postpayment rule to apply to all relevant claims. PPI then monitors the new prepayment rule to ensure effectiveness by measuring whether the change to a prepayment rule produced the same or better results as the postpayment savings realized prior to moving the rule. We archive each updated rule logic for audit information, lessons learned, and logic research.

Prepayment Claim Edits: Prior to payment, CAS finds claims with inconsistent data such as type code, group number, or contracted provider number, and then flags the claim as requiring manual processing. We also conduct prepayment reviews either as part of a planned review or because of a flag in our system. We assign these claims to our adjustors in our Claims Processing team, who are highly trained within their specialized claim types. Our adjustors identify trends and conduct root cause analyses to correct issues.

Prepayment Reviews: Our PPI unit routinely conducts prepayment reviews. Examples of our PPI unit's most common areas of prepayment reviews are:
*   Provider billing and coding errors (e.g., excessive charges or selection of wrong codes, which may result in a higher than appropriate payment)
*   Lack of documentation to support the services or days billed
*   Services not rendered (e.g., duplicative charges)
*   Level of care validation and preventable readmission
*   Clinical diagnosis validation (e.g., lack of objective clinical information in the medical record to support the condition for which services were billed)
*   Diagnosis Related Group (DRG) upcoding

The PPI unit also completes medical record reviews that focus on:
*   Billing and coding errors
*   Medical necessity reviews
*   Services not rendered
*   Level of care validation
*   Preventable readmission
*   Clinical diagnosis validation

Data Analytics: In addition to these reviews and audits, PPI also routinely conducts prepayment reviews for both network and out-of-network (OON) providers, either as part of a planned review to detect FWA or as a result of a FRAC referral. PPI uses complex data analytics, including outlier analysis, trending, and link analysis, to identify potential waste and abuse. Humana has developed a strong set of in-house, proprietary data models to identify suspicious behavior prior to payment.

Humana has a series of proprietary data models we run on a recurring basis to detect fraud scenarios such as providers over-prescribing controlled substances, Enrollees displaying doctor shopper behavior by visiting multiple providers and pharmacies with multiple prescriptions for controlled substances, providers potentially unbundling codes, and pharmacy claims lacking corresponding medical claims. █████████████████

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Innovations in Prepayment Reviews: In 2019, Humana's SIU Director, David Popik, created a new team, the Fraud Response Team, to proactively identify new and emerging areas of FWA. The team is comprised of senior investigators with a highly-specialized skill set. The Fraud Response Team coordinates with FRAC to identify and mine data elements to create new processes and address new and emerging areas of FWA. While their work includes both pre- and postpayment activities, it has resulted in changes to prepayment edits and reviews. For example, Humana utilizes a new process to review non-participating providers who submit claims, our Non-Participating Provider Verification Process (PPG), to identify sham providers. We have new prepayment processes to address schemes related to telehealth providers to identify improper telesolicitation schemes (e.g., compounds for foot creams, DME such as back braces, etc.), genetic testing, and mail order pharmacies.

Prepayment Review Notifications: Because the SIU is Humana's investigative unit, it completes prepayment reviews (as they are defined by Section 36.2 of the Draft Medicaid Contract). In accordance with this section and written policies and procedures, the SIU notifies providers in writing of:

- The specific reason for the review
- Complete description of the specific document needed for the review
- Description of the method of submission
- Timeframe for returning the documentation
- Notice that the claim will be denied if the documentation is not returned in a timely manner
- Length of the review
- Contact information
- Information on how the provider may request removal of the prepayment review

The SIU tracks these approvals in FIT, including a case number, Enrollee's name/ID, the subject of the review and whether the prepayment review includes a site visit.

The SIU also has procedures in place to notify the Department within 15 days if any provider has been placed on prepayment review. Specifically, the SIU associate assigned to the case notifies their immediate manager or investigative lead and documents the case in the SIU Case Documentation System. The SIU associate then notifies the Department, including at a minimum the following information:

- Case number
- Provider name
- Medicaid Provider ID
- NPI

- Summary of Concern
- Date action was taken

CCM Compliance will then upload the approved notification onto the Entrust Entelligence Messaging Server on the DMS website, include the SIU Investigator in the email, and document appropriately within the SIU Case Documentation System. Annually, CCM Compliance submits a listing of all providers under Prepayment Review.